

REMARKS OF HENRY A. WAXMAN  
CHAIRMAN  
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT  
BEFORE  
NATIONAL COUNCIL OF COMMUNITY HOSPITALS  
NOVEMBER 12, 1982

I'M VERY PLEASED TO HAVE THIS OPPORTUNITY TO JOIN YOU TODAY, AND  
THANK YOU FOR INVITING ME TO MEET WITH YOU.

I'D LIKE TO START BY TRYING OUT A HOSPITAL ADMINISTRATOR JOKE ON  
YOU. IT'S BASED ON THE OLD "LIGHTBULB JOKE" FORMAT. FOR INSTANCE,

HOW MANY CALIFORNIANS DOES IT TAKE TO CHANGE A LIGHT BULB?

THREE: ONE TO CHANGE THE BULB, AND TWO TO SHARE THE EXPERIENCE.

NOW THAT YOU'VE GOT THE HANG OF IT, HOW MANY HOSPITAL  
ADMINISTRATORS DOES IT TAKE TO CHANGE A LIGHTBULB?

THE ANSWER?

FOUR:

-- ONE TO GET A CERTIFICATE OF NEED FOR A NEW BULB;

-- ONE TO FIGURE MEDICARE REIMBURSEMENT FOR THE PURCHASE;

--ONE TO CONVINCING THE TRUSTEES THAT A BULB IS NEEDED; AND

--ONE TO CONVINCING THE MEDICAL STAFF THAT A COMPUTERIZED BATTERY OF SEVENTEEN SPOTLIGHTS IS NOT NEEDED.

TODAY, HOWEVER, I WANT TO DISCUSS ISSUES ABOUT WHICH ADMINISTRATORS, TRUSTEES, AND MEDICAL STAFF SHOULD AGREE.

AS YOU ARE PAINFULLY AWARE, WE ARE NOW CONFRONTING SOME DEEPLY DISTURBING CHALLENGES TO OUR PUBLIC COMMITMENT TO FINANCE AND DELIVER HEALTH CARE TO OUR NATION'S POOR AND ELDERLY CITIZENS.

FOR THE PAST TWO YEARS, THE REAGAN ADMINISTRATION HAS PURSUED A SIMPLE AND HARSH STRATEGY. THE ADMINISTRATION WANTS TO CUT FEDERAL HEALTH SPENDING BY SHIFTING THE COSTS OF CARING FOR THE POOR AND THE ELDERLY ONTO THE STATES, THE COUNTIES, THE PATIENTS, THE PRIVATE SECTOR, AND ANYONE ELSE AVAILABLE.

FOR THOSE OF US FROM CALIFORNIA, THIS CAME AS NO SURPRISE. THE PRESIDENT HAS ADVOCATED DRAMATIC HEALTH PROGRAM CUTS FOR MANY YEARS. WHEN MR. REAGAN WAS GOVERNOR OF CALIFORNIA, HE PUSHED THROUGH MEDICAL CHANGES THAT DRAMATICALLY SHIFTED COSTS TO THE COUNTIES.

THE RESULT WAS PREDICTABLE. COUNTIES BEGAN TO CUT BACK ON THEIR HEALTH CARE SERVICES. SOME EVEN CLOSED THEIR PUBLIC HOSPITALS. COMMUNITY HOSPITALS WERE EXPECTED TO HELP PICK UP THE PIECES -- WITHOUT ANY COMPENSATION FOR THEIR COSTS. MEDICAL CARE BECAME LESS AVAILABLE FOR THE POOR AND NEEDY.

THE ADMINISTRATION'S FEDERAL HEALTH POLICY HAS BEEN A GRADE-B RE-RUN OF ITS 1971 MEDICAL CHANGES. IT HAS ATTEMPTED TO SHIFT THE RESPONSIBILITY FOR FINANCING HEALTH CARE FOR THE POOR FROM THE FEDERAL GOVERNMENT TO THE STATES. NOT SURPRISINGLY, THE STATES ARE TURNING AROUND AND SHIFTING THE COSTS ONTO LOCAL GOVERNMENTS AND COMMUNITY HOSPITALS.

LET'S LOOK A LITTLE MORE CLOSELY AT WHAT HAPPENED. IN HIS FIRST BUDGET PRESIDENT REAGAN PROPOSED 11 BILLION DOLLARS IN MEDICARE AND MEDICAID CUTS OVER THREE YEARS. THE MOST IMPORTANT OF THESE WAS THE PROPOSED "CAP" ON FEDERAL MEDICAID PAYMENTS TO THE STATES.

WE FOUGHT THAT BUDGET AS VIGOROUSLY AS WE COULD. WE SUCCEEDED IN REDUCING THE PROPOSED CUTS BY ABOUT 40 PER CENT. AND WE BEAT BACK THE "CAP" TO PRESERVE THE MEDICAID ENTITLEMENT. BUT WE ENDED UP WITH 6.5 BILLION DOLLARS IN FEDERAL PROGRAM CUTS OVER 3 YEARS.

THE MOST DEVASTATING WAS THE 3 BILLION DOLLAR MEDICAID CUT, COMING LARGELY FROM A THREE-YEAR REDUCTION IN FEDERAL MATCHING PAYMENTS TO THE STATES. THIS SEVERE COST SHIFT HAS PUT MAJOR PRESSURE ON THE STATES TO CUT THEIR PROGRAMS.

IN HIS SECOND BUDGET, SUBMITTED TO THE CONGRESS LAST FEBRUARY, THE PRESIDENT PROPOSED MORE OF THE SAME. HE ASKED FOR ANOTHER THREE-YEAR CUT IN MEDICARE AND MEDICAID -- THIS TIME TOTALLING 24 BILLION DOLLARS.

ONCE AGAIN, WE FOUGHT THE BUDGET. WE SUCCEEDED IN REDUCING THE MAGNITUDE OF THE CUTS BY 45 PER CENT. BUT WE STILL ENDED UP THIS AUGUST WITH A 13 BILLION DOLLAR REDUCTION OVER THE NEXT THREE YEARS.

OUR MAJOR VICTORY IN DAMAGE CONTROL THIS YEAR WAS MEDICAID. WE COULD NOT ACCEPT THE ADDITIONAL 8 BILLION DOLLAR THREE-YEAR CUT IN MEDICAID THAT THE ADMINISTRATION PROPOSED. STATES SIMPLY COULD NOT AFFORD IT.

WE WERE ABLE TO PERSUADE OUR COLLEAGUES TO LOWER THE MEDICAID CUT TO 1 BILLION DOLLARS OVER THE NEXT THREE YEARS. THIS IS CERTAINLY AN IMPROVEMENT, BUT WILL STILL BE DIFFICULT FOR THE STATES TO DEAL WITH.

MEDICARE DID NOT FARE NEARLY SO WELL. THE PROGRAM WAS CUT BY 12 BILLION DOLLARS WITH ABOUT 80% OF THE REDUCTIONS COMING FROM HOSPITAL AND PHYSICIAN REIMBURSEMENT. AS YOU KNOW, ROUGHLY HALF OF THESE FEDERAL SAVINGS COME FROM THE NEW LIMITS ON MEDICARE HOSPITAL COSTS PER ADMISSION.

LET'S LOOK AT THE RESULTS OF THESE BUDGET CUTS. A SPECIAL COMMISSION OF THE AMERICAN HOSPITAL ASSOCIATION HAS ISSUED AN IMPORTANT STUDY THAT DOCUMENTS WHAT HAPPENS TO PEOPLE WHEN GOVERNMENT CUTS BACK. LET ME SHARE WITH YOU THE SIX FINDINGS THAT THE REPORT HIGHLIGHTS.

- O FIRST, THE MOST VULNERABLE CITIZENS ARE HURT THE MOST;
- O SECOND, THE MEDICAID CUTS DWARF THE MEDICARE CUTS;
- O THIRD, THE STATES HAVE FOLLOWED NO SET PATTERN IN THEIR MEDICAID CUTS. THE RESULT IS THAT WE ARE MOVING AWAY FROM THE GOAL OF HEALTH SECURITY FOR THE POOR AND DISABLED. AND IT ALSO MEANS THAT THE GAPS IN SERVICES AND POPULATIONS COVERED ARE GETTING WORSE.
- O FOURTH, THE BURDEN OF THE CUTS FALLS ON A MINORITY OF HOSPITALS AND OTHER AGENCIES;
- O FIFTH, THE INEQUALITY IN THE PROVISION OF CHARITY CARE, COUPLED WITH THE FUNDING CUTS, HAS FOSTERED A GREAT DEAL OF DIVISIVENESS AMONG THE NATION'S HOSPITALS .
- O SIXTH, AND MOST SERIOUS OF ALL, THE COMMITTEE REPORTED THAT THE PROBLEMS WILL GET WORSE.

THAT IS INDEED A SOBERING ASSESSMENT. BUT IT TELLS US EXACTLY WHERE THE PRESIDENT'S HEALTH POLICY IS TALKING US.

WE DO NEED TO TRY TO CONTROL COSTS UNDER MEDICARE, MEDICAID, AND PRIVATE HEALTH INSURANCE. THERE IS NO QUESTION THAT THE CURRENT RATES OF INCREASE IN HEALTH CARE EXPENDITURES HAVE OUTPACED THE GROWTH IN TAX REVENUES. THESE INCREASES HAVE TO BE MODERATED.

BUT THE REAGAN STRATEGY FOR CONTROLLING COSTS IS NEITHER EFFECTIVE NOR FAIR. IT MEANS THAT EACH PAYOR -- MEDICARE, MEDICAID, THE BLUES, THE COMMERCIALS -- TRIES TO MINIMIZE ITS OUTLAYS, WITH NO REGARD FOR THE EFFECTS OF ITS POLICIES ON OTHERS.

WHEN EACH PURCHASER VIGOROUSLY PROTECTS ITS OWN BENEFICIARIES AND ITS OWN BUDGET, AND PUBLIC PROGRAMS PAY THE LOWEST POSSIBLE PRICE, WE ARE FORCED TO CONFRONT THREE CRITICAL ISSUES THAT WE HAVE MANAGED TO IGNORE OVER THE PAST 15 YEARS.

O FIRST, ARE WE GOING TO MAINTAIN A PUBLIC COMMITMENT TO MAINSTREAM MEDICAL CARE FOR THE AGED, DISABLED, AND POOR? THE PROGRAM CHANGES WE SEE, SUCH AS THE SELECTIVE CONTRACTING PROGRAM IN CALIFORNIA'S MEDICAID PROGRAM, MOVE US AWAY FROM THAT GOAL AND TOWARD A TWO TRACK SYSTEM OF CARE. I HOPE THAT YOU SHARE MY COMMITMENT THAT THIS NATION IS GREAT ENOUGH TO CONTINUE TO STRIVE FOR MAINSTREAM CARE FOR ALL OUR CITIZENS.

O SECOND, HOW DO WE FINANCE CARE FOR THOSE WHO HAVE NO COVERAGE? WHO PAYS FOR THE MEDICALLY INDIGENT ADULT, THE UNINSURED POOR, THE UNEMPLOYED WORKER, AND THE ILLEGAL ALIEN? YOUR INSTITUTIONS, AND ESPECIALLY THE PUBLIC HOSPITALS, HAVE MANAGED TO SERVE MANY OF THESE INDIVIDUALS IN THE PAST. BUT IF EACH PAYOR SUCCEEDS IN PROTECTING JUST ITS BENEFICIARIES AT THE LOWEST PRICE, WE WILL HAVE ELIMINATED SOURCES OF REVENUES AT THE VERY TIME THAT THE NUMBER OF UNCOVERED INDIVIDUALS IS DRAMATICALLY INCREASING.

O FINALLY, HOW ARE WE GOING TO FINANCE VITALLY NEEDED HOSPITAL AND HEALTH SERVICES AT LEVELS ABOVE THE "LOWEST PRICE" LEVEL? WE DON'T ALWAYS NEED THE MOST EXPENSIVE, HIGH-TECHNOLOGY CARE. BUT WE MUST HAVE IT IN SOME MEDICAL SITUATIONS, AND WE MUST FINANCE THAT CARE. SOURCES OF NEW CAPITAL AND MEDICAL EDUCATION ARE SEVERELY CONSTRAINED WHEN EVERYONE PAYS FOR JUST THEIR OWN PATIENT CARE.

THESE ARE ISSUES THAT WERE OBSCURED FOR MANY YEARS BY THE INCREASED FUNDING UNDER MEDICARE AND MEDICAID.

BUT WE WILL NOT BE ABLE TO IGNORE THEM MUCH LONGER, AND WE CAN EXPECT THE ADMINISTRATION TO CONTINUE ITS BUDGETARY PRESSURE TO MAKE THINGS WORSE.

OVER THE PAST TWO YEARS, THIS BUDGET PRESSURE HAS FORCED A RE-EXAMINATION OF THE ENTIRE MEDICARE REIMBURSEMENT SYSTEM. IN THIS YEAR'S TAX BILL CONGRESS DIRECTED THE ADMINISTRATION TO DEVELOP A NEW PROSPECTIVE REIMBURSEMENT PROPOSAL.

YOU HAVE UNDOUBTEDLY READ ABOUT THE PROPOSAL THEY HAVE COME UP WITH. ALTHOUGH ONLY THE BROADEST OUTLINES HAVE BEEN SHARED WITH THE CONGRESS, IT APPEARS THAT THE DEPARTMENT HAS DECIDED TO RELY ON "DIAGNOSTICALLY RELATED GROUPS" OR DRG'S AND TO RULE OUT ANY OTHER OPTION AT THE STATE OR FEDERAL LEVEL.

EVER SINCE THE HOSPITAL COST CONTAINMENT DEBATE, IT HAS BEEN CLEAR THAT A GOOD REIMBURSEMENT SYSTEM SHOULD REWARD EFFICIENT HOSPITALS AND PENALIZE INEFFICIENT ONES. TO DO THIS, WE NEED TO UNDERSTAND THE KINDS OF PATIENTS AT EACH FACILITY. DRG'S ARE PERHAPS THE BEST TOOL WE HAVE NOW AVAILABLE TO FIND THIS OUT.

BUT WE KNOW THAT DRG'S HAVE THEIR LIMITATIONS.

THERE ARE STILL REAL QUESTIONS ABOUT THE ACCURACY OF THEIR MEASUREMENT OF HOW SICK A PATIENT IS. AND IT'S CERTAINLY CLEAR THAT THEY CAN BE BENT AND DISTORTED TO GET THE MOST REIMBURSEMENT POSSIBLE.

ALTOGETHER, WE NEED TO KNOW MORE ABOUT THE SYSTEM BEFORE IMPLEMENTING IT ON A NATIONWIDE BASIS AND LOCKING OURSELVES INTO A PROGRAM IT MAY BE VERY DIFFICULT TO GET OUT OF.

AND WE CERTAINLY NEED TO BE CAREFUL ABOUT DISTURBING THOSE STATE COST CONTAINMENT PROGRAMS THAT HAVE ALREADY PROVEN THEMSELVES USEFUL. REGARDLESS OF WHAT WE DO NATIONALLY, THERE WILL ALWAYS BE THOSE STATES THAT CAN HANDLE THEIR REIMBURSEMENT PROBLEMS MORE EFFECTIVELY USING ACROSS-THE-BOARD METHODS OF THEIR OWN.

I AM ALSO CONCERNED ABOUT HOW ANY METHOD OF PROSPECTIVE REIMBURSEMENT ADDRESSES THE FUNDING OF CAPITAL AND OF MEDICAL EDUCATION. UNDER THE DEPARTMENT'S PRESENT PROPOSAL, THESE COSTS ARE TO BE PASSED THROUGH. THESE ARE VERY DIFFICULT ISSUES, AND IT IS NOT CLEAR TO ME THAT THIS SOLUTION HAS BEEN THOUGHT THROUGH.

FINALLY, I AM CONCERNED THAT ANY PROSPECTIVE REIMBURSEMENT POLICY ADDRESS THE SPECIAL PROBLEMS OF THOSE INSTITUTIONS THAT SERVE LARGE NUMBERS OF MEDICARE AND MEDICAID PATIENTS. THE DEPARTMENT'S PROPOSAL APPEARS TO IGNORE THAT PROBLEM ALSO. CONGRESS AND THE ADMINISTRATION HAVE TO BE SENSITIVE TO THE GREATER NEEDS OF HOSPITALS THAT TREAT PUBLIC PATIENTS.

IT IS CLEAR THAT SOME REFORMS MUST OCCUR IN THE MEDICARE PROGRAM, BUT I AM CONCERNED THAT THE PROPOSALS THAT ARE BEING MADE ARE MADE THOUGHILESSLY AND WITHOUT CONSIDERATION FOR THE EFFECTS ON PATIENTS AND HOSPITALS.

AS WE ENTER THE COMING YEAR, WE MUST FACE THE FACT THAT THE ADMINISTRATION'S TAX AND ECONOMIC POLICIES HAVE RESULTED IN DEFICITS PROJECTED AT MORE THAN \$150 BILLION. THERE WILL BE INTENSE PRESSURE TO FURTHER REDUCE MEDICARE AND MEDICAID OUTLAYS, PARTICULARLY IF THE PRESIDENT INSISTS ON TRYING TO "STAY THE COURSE."

ALREADY WE HEAR ABOUT TOTALLY UNACCEPTABLE PROPOSALS FOR INCREASED COST SHARING, MEANS TESTS FOR MEDICARE, AND FURTHER REIMBURSEMENT LIMITS.

OBVIOUSLY, STAYING THE COURSE IS NOT GOING TO WORK. WE CAN NO LONGER AFFORD A FEDERAL HEALTH POLICY THAT UNFAIRLY SHIFTS COSTS ELSEWHERE AND IGNORES THE REAL PROBLEMS CONFRONTING US.

WE NEED TO RECONSIDER THE DRASTIC INCOME TAX CUTS THE ADMINISTRATION PUSHED THROUGH CONGRESS IN 1981. THESE CUTS HAVE GONE DISPROPORTIONATELY TO AMERICA'S WEALTHIEST INDIVIDUALS AND CORPORATIONS. IF WE DON'T RECOVER SOME OF THESE LOSSES, WE WILL NEVER BE ABLE TO FINANCE ADEQUATE PUBLIC PROGRAMS.

WE NEED TO RECONSIDER THE DECISIONS TO SLASH MEDICAID PAYMENTS TO STATES. SUCH COST-SHIFTING IS PARTICULARLY INAPPROPRIATE IN A RECESSION, WHEN STATE REVENUES ARE DOWN AND THE DEMAND FOR ASSISTANCE IS UP.

WE NEED TO RECONSIDER THE POLICY OF LIMITING ONLY REIMBURSEMENTS FOR PATIENTS IN PUBLIC PROGRAMS AND CONCERN OURSELVES WITH THE POTENTIAL DISCRIMINATION AGAINST MEDICARE AND MEDICAID BENEFICIARIES THAT SUCH A POLICY INVITES.

WE NEED TO CONFRONT THE DEMOGRAPHIC REALITY OF A RAPIDLY GROWING ELDERLY POPULATION, AND THE NEED FOR LONG-TERM CARE FOR MANY OLDER AMERICANS.

FINALLY, WE NEED TO EXTEND HEALTH INSURANCE COVERAGE TO THE ROUGHLY 10 PERCENT OF THE POPULATION THAT LACKS ANY PUBLIC OR PRIVATE PROTECTION WHATSOEVER.

IN THE SHORT TERM, THE KEY OBJECTIVE FOR US SHOULD BE TO CALL A HALT TO OUR ANNUAL BUDGETARY MADNESS. WE RUN A GRAVE RISK THAT FURTHER CUTS WILL DAMAGE OUR HEALTH SYSTEM IN UNACCEPTABLE AND IRREPARABLE WAYS.

I WILL DO EVERYTHING I CAN IN THE COMING CONGRESS TO AVOID FURTHER CUTS AND TO WORK TO ADDRESS THESE CRITICAL ISSUES. I LOOK FORWARD TO WORKING WITH YOU IN THAT EFFORT.